crease in the globulins and a leucocyte count of 11.8. On account of the faulty position of the lower extremities in flexion and the possibility of contractures, the orthopedic surgeons were called in consultation. On September the 1st, or about three weeks after patient was admitted, a lumbar puncture was done under great difficulty, the fluid being contaminated by an admixture of blood. There were but 10.5 leucocytes per cu. m. m. with some increase in the globulin, which might have been accounted for by the normal blood content of white cells. This count was, however, not satisfactory. This patient left the hospital after the last puncture and has not since been heard from.

Case V. S. R., male, age 3½—Stanford Dispensary No. 98753—Pre-paralytic symptoms lasting three days, commencing with headache and a temperature of 102° F. The fever fell on the second day, but the child was languid and rather stuporous. The third day he was unable to stand because of paralysis of the right leg. This was on September the 20th. Examination showed flaccid paralysis of the right leg in extension, the leg being externally rotated and the foot everted. The tendon reflexes of this extremity were not elicited. No evident objective sensory disturbances. The left leg showed no paralysis. A very striking feature of this case was pain and tenderness on passive motion or pressure of the affected leg muscles, and also of the left leg muscles, but to a considerably less extent. The spinal fluid examinations were as follows:

	Leucocytes	Globulin
September 23, 1921.....	32	positive
September 27, 1921.....	11.2	"
October 12, 1921.....	48	"
October 29, 1921.....	3.1	negative

When last seen (October the 29th) the power of flexion and extension of the right thigh was possible, but no motion was present at the knee or in the toes. The tenderness was decreasing but still present.

It occurred to us to seek some references regarding the spinal fluid content following acute poliomyelitic paralysis. Whereas Draper gives no data concerning the fluid after the first few days, Ruhrah and Mayer state that "cells disappear rapidly so that after two weeks the count is either normal or nearly so."

This is probably the case in most instances, but in our series the persistence of the fluid reactions most probably indicated a meningeal origin of pain in the third and fifth cases, the former showing an increase in the cells for more than two months, and the third not clearing until one month. Unfortunately, the most typical case of pain, or the second case, we were not able to thoroughly study from the standpoint of meningeal reactions.

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STANFORD COLLOQUIA AT THE SAN FRANCISCO HOSPITAL

Surgical — (By Dr. Sterling Bunnell) — Our first patient is a middle-aged Mexican woman, with extensive tubercular enlargement of the cervical glands of all of the triangles in the left side of the neck. There is an especial enlarged one, probably with abscess, under the upper part of the sternocleidomastoid muscle. She noticed enlarged glands here for six years, though the greatest enlargement has taken place in the last month; this probably from abscess formation. Pathology of this degree is beyond cure by X-ray. I feel that X-ray and hygiene is the best treatment for beginning tubercular adenitis.

Surgery of this condition has gained ill repute because often merely the enlarged glands, and not the gland bearing tissue, has been removed from the neck. Considering this, it is not at all surprising that recurrent cervical enlargements are so frequent after operative removal. It is my conviction that the proper way to remove the glands and gland bearing tissue is en bloc, just as we do for carcinoma. It has been my experience that whenever the whole tubercular gland bearing mass has been removed in one piece, without tearing the tissue and spreading the germs about, that that patient has been cured, providing that the tonsils are removed and that there is no other tubercular focus. In such cases I have never seen local recurrence. A block dissection was then done and because of the magnitude of the operation it was followed by a transfusion of 900 cc. of blood. This reduced the pulse from 140 to 90.

The next patient is a woman forty years of age and very fat, who has had typical attacks of gall stones for six years. The present attack has lasted a week and was accompanied by a temperature of 101. About the lower part of the abdomen is a huge roll of fat, which suggests the necessity for a lipectomy, but peculiarly enough the layer of free peritoneal fat is as scanty as in a thin person. This, together with the finding of an infantile uterus, suggests hypopituritarism. The gallbladder is somewhat enlarged and congested, slightly thicker walled and more gray than normally and adherent to the neighboring viscera. The surface of the liver in the immediate vicinity shows a ribbing of scar tissue and along the cystic duct and common duct can be felt several enlarged glands. The pancreas is slightly harder than normal. Many stones can be felt in the gallbladder. In this case we have a full set of signs of cholecystitis. Quite often, however, we have a good history of cholecystitis and no gross signs in the gallbladder, except perhaps the enlargement of the telltale gland along the cystic duct. In such a case it is best to be guided by the history and remove the gallbladder. . . .

Our next case is that of an injury to the knee joint, caused by sitting upon it with the leg in the abducted position. There is local tenderness over the internal lateral ligament and pain is produced when the leg is abducted. There is also a greater degree of lateral motion in the injured leg compared with her normal leg. It

is, therefore, concluded that there has been a rupture of some of the fibers of the internal lateral ligament. This ligament is uncovered through a semilunar incision and a longitudinal incision is made through it. Through a small hole in the capsule of the joint the internal articular cartilage is explored and found to be normal. For a distance of about two centimeters the fibers of the internal lateral ligament are seen to have been torn. A strip of fascia is taken from the fascia lata of the same leg and transplanted under the internal lateral ligament, contacting with the tibia below and the femur above and the incisions are repaired. The free fascial graft, together with the resulting reaction in the surrounding ligamentous tissues, will result in so re-enforcing the internal lateral ligament as to effect a cure. This principle can be applied to a chronically spraining ankle. Fascia and ligaments are the safest tissues to graft and will live even when but one surface is contacted with vascular tissue.

Obstetrical and Gynecological— (By F. R. Girard)—Ovarian transplants: The patient before us is a gravida IV para II, thirty years old. Menstruation of the normal thirty-day type of four to five days' duration began at 14. Since an abortion, six years ago, menstruation has been every three to five weeks, accompanied by severe pain in both lower quadrants, down thighs and associated with backache. Vaginal examination shows no evidence of inflammatory disease; a small cervix with bilateral lacerations. The uterus normal in size, position, outline and consistency, but motion is limited by adherent adnexa to lateral pelvic walls. Operation shows both adnexa buried in dense adhesions to lateral walls and floor of the pelvis; left adnexa also adherent to sigmoid; posterior surface of cervix adherent to sigmoid; body of uterus normal; bilateral salpingo-oöphorectomy; blood supply of both ovaries badly damaged during enucleation and much raw surface on ovaries; bilateral hydrosalpinx.

Comment: A healthy uterus in a thirty-year-old patient makes this an ideal case for ovarian auto-transplantation. It is evident that these ovaries must be removed, and by removing the cystic areas from both ovaries and also the markedly thickened and sclerotic capsule we can place two grafts at the upper and lower angles of the incision in pockets prepared on top of the anterior rectus sheath.

Question—What are the chances of the grafts sloughing out?

Answer—By using multiple small grafts a much larger surface is obtained for establishment of new blood supply and by being careful to use ovaries which are not involved in acute inflammatory processes I have been able to secure grafts which have lived and functionated in all of the twenty cases of my experience.

Question—How long do you expect it to take before menstruation is re-established?

Answer—That varies with different patients. The shortest time from operation to first menstrual flow was five weeks and the longest time was six and a half months. Regarding length of time that patients menstruate after auto-grafting, my personal experience has been that cases grafted approximately two and a half years ago are still menstruating regularly and in a satisfactory manner. Professor Tuffier of Paris has, from a large series of cases, determined that the menstrual life after auto-grafts is approximately from two and a half to three and a half years. It is most gratifying to see the freedom from the distressing nervous, atrophic, nutritive and vaso-motor disturbances that these patients have when auto-transplantation has been done and menstruation preserved.

Medical Fees Under the Workmen's Compensation Act—It is believed that concrete examples of rulings upon medical fees may be of use to physicians in more ways than one. The following ruling in an actual case is furnished by Morton R. Gibbons, M. D., Medical Director, Industrial Accident Commission:

"My understanding is that your services involved a journey of 106 miles, being 53 miles one way; that the injury for which you attended the injured employe was a compound jagged fracture of the humerus three inches below the head, dislocation of the head of the humerus, and twelve small lacerations and four large lacerations, together with dangerous hemorrhage from many lacerated blood vessels. Your services included reduction of the fracture under anaesthesia and reduction of the dislocation; also the repair of twelve small wounds and four large wounds above mentioned; also ligation of several bleeding vessels. In addition to this there was the necessary treatment of shock, and application of retentive appliances.

According to the Fee Schedule you are entitled to fees as follows:

For reduction of the fracture of the humerus, compound	$ 60.00
Reduction of dislocation of the head of the humerus with complications	20.00
Repair of twelve small wounds. (N. B.—In multiple small wounds it is not logical to charge full fees for each.)	20.00
Repair of four large wounds. (N. B.—It is noted that several of these wounds are of great extent, more than contemplated in the minimum of the Fee Schedule.)	20.00
Mileage, 53 miles one way	39.75
For sutures, medicines and materials	2.70
This makes a total of	$162.45

A large latitude in judgment must be left to the surgeon who sees the case in emergency. If in his judgment, knowing his own facilities, his own skill and experience, and most of all, the needs of the patient, it would be better to treat him extensively without delay, he should certainly do so. Failure to perform the proper service at the proper time when it is possible to do so, entails danger of malpractice suit against the doctor, no matter whose rule he may be following or what employer's criticism he may incur later.

From the information which you give me and what I gather from your correspondence, it is my opinion that you did right in treating your injured man as you did."

The Hotel Casa Del Mar, near Venice, California, will be opened in a few days as a hospital of about 100 beds. William G. Lutz is superintendent.

The William H. Lewis Memorial Hospital has been opened at Atascadero, California. The hospital has 30 beds, including 12 private rooms. Charles A. Love, M. D., is director of the institution.